TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAYLOR SURGICARE AT NORTH DALLAS

Respondent Name
WORTH CASUALTY CO

MFDR Tracking Number
M4-17-2661-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MAY 9, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was NOT PAID ACCORDING TO THE 2016 Texas Ambulatory Surgical Center Fee Schedule."

Amount in Dispute: $920.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per AMA and CMS guidelines referenced above, -F9: Right hand, 5th digit, is not an applicable modifier for CPT code 15002. CPT code 15002 reflects a surgical procedure to the trunk, arms and legs…Corvel will maintain the requestor…is not entitled to additional reimbursement for date of service 08/03/2016 in the amount of, $920.12 based on improper application of a modifier to describe procedures or services that refer to anatomical location."

Response Submitted By: CorVel Healthcare Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 3, 2016	Ambulatory Surgical Care for CPT Code 26951-F9	$0.00	$0.00
	Ambulatory Surgical Care for CPT Code 15002-F9	$920.12	$0.00
	Ambulatory Surgical Care for CPT Code 15240-F9	$0.00	$0.00
TOTAL		$920.12	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. Texas Labor Code 413.011(b) provides for additions or exceptions to the Medicare policies.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 59-Allowance based on Multiple Surgery Guidelines.
   - RD9-Multiple Procedure/3rd or Subsequent (50%).
   - F9-Right Hand, fifth digit.
   - 193-Original payment decision is being maintained.
   - W3-Appeal/reconsideration.

Issues

Is the requestor entitled to reimbursement for CPT code 15002-F9?

Findings

On the disputed date of service, the requestor billed CPT codes 26951-F9, 15002-F9, and 15240-F9. The respondents paid for codes 26951-F9, and 15240-F9 and are not in dispute. The respondent reduced payment for code 15002-F9 based upon reason codes "59" and "RD9."

28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

HCPCS code 15002 is defined as "Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children."

The requestor appended modifier "59" to code 15002. Per AMA and CMS guidelines, this modifier is not applicable to code 15002.

A review of the submitted report does not support billing CPT code 15002; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	06/07/2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.